From: To: 2024429430 04/14/2009 21:55 #568 P. 002/021 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/07/2009 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G031 03/17/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI-SERVICES, INC 4314 9TH STREET NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY -{W:000} **INITIAL COMMENTS** {W 000} TAIF A revisit survey was conducted on March 17, 2009. The Plan of Correction for the August 21, GOVERNMENT OF THE DISTRICT OF COLUMBIA 2008 recertification survey, which was submitted DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION by the facility on September 15, 2008, was the 825 NORTH CAPITOL ST., N.E., 2ND FLOOR focus of this revisit survey. The facility was providing services and supports for six women WASHINGTON, D.C. 20002 with various disabilities. The findings of this survey were based on observations, interviews with staff and clients in the home, as well as a review of client and administrative records, including the incident management system. 483.410(a)(1) GOVERNING BODY Nursing staff will receive train W 104 ing on procedures for medication The governing body must exercise general policy, administration. budget, and operating direction over the facility. 4/24/09 This STANDARD is not met as evidenced by: Based on interview and record review, during the follow-up survey on March 17, 2009, the governing body failed to exercise operating direction over the facility as evidenced below: The findings include: [Cross refer to W331] The Governing Body failed to ensure that it's Procedures for Medication Administration were implemented as written to prevent a medication error for Client #1. The review of unusual incidents on March 17, 2009 at approximately 11:30 AM, revealed that on October 28, 2008, at 6:15 AM, Client #1 was administered Client #4's morning medications by the medication nurse. The corresponding

RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I1YJ12

ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the justitution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility ID: 09G031

If continuation sheet Page 1 of 8

(X6) DAZE

From: To: 2024429430 04/14/2009 21:55 #568 P. 003/021 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/07/2009 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 09G031 03/17/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) W 104 Continued From page 1 W 104 investigative statement documented that the client was closely monitored and remained lethargic until approximately 3:30 PM on that day. 1 A nursing progress note written by the evening DE medication nurse on October 28, 2008 at approximately 5:30 PM revealed that the client was up and about, minimally lethargic, had slurred speech, and tolerated her evening meal. The evening medication nurse also documented that Client #1's evening medications were held and that the supervisor would be notified. Interview with the Director of Nursing on March 17, 2009 revealed that the agency had a written "Procedure for Medication Administration" which provided guidelines to the medication nurse and the staff. The review of the Procedure for Medication Administration revealed the following steps steps should be implemented. a. The nurse must ... Administer the medications per physician's ...Prepare each client's medication and administer it before preparing for the next client ...Request assistance from group home staff

administered.

b. Group home staff must...

..Bring one client at a time to the medication room and remain with the client until the medication is

There was no evidence the facility ensured its Procedures for Medication Administration were implement as written. The evidence revealed that the failure to implement the Procedures for Medication Administration as written, resulted in

		H AND HUMAN SERVICES  8 MEDICAID SERVICES			PRINTED: 04/07/2009 FORM APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU	LTIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	•	09G031	B. WING		R
]	PROVIDER OR SUPPLIER	es, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011	03/17/2009
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OULD BE COMPLETION
W 104 {W 322}	Continued From pa Client #1 receiving medication on Octo 483.460(a)(3) PHY	Client #4's morning ber 28, 2008.	W 10		
CA SPAT: SPAT:	The facility must progeneral medical car	ovide or obtain preventive and e.			
	Based on interview failed to ensure reco	onot met as evidenced by: and record review, the facility commended laboratory obtained timely for one of ample. (Client #2)		The Prolactin level for #2 was completed on 4/2/ the future, the primary will review physicians endation for follow-up to	09. In nurse recom-
	review of Client #2's	at approximately 2:15 PM, physician's orders (POs).	į	pharmacy review and other tants recommendations on basis. The Director of N will review clients medi	r consul- a monthly ursing
(b .	Prolactin Level". Fu	er 26, 2008 order to "Monitor orther record review revealed 8 physician's order which rel every 6 months"		ords on a quaterly basis	
<b>科等</b> "〈	Professional (QMRP PM, revealed there v file for Client #2. Fu QMRP indicated that Director of Nursing to	Jaiified Mental Retardation ) on March 17, 2009 at 2:35 were no Prolactin levels on ther interview with the she would follow-up with the determine if Client #2's seen assessed as prescribed.			
r s v	on March 17, 2009 fa client's Prolactin leve should be noted that pharmacist conducte which he recommend	f Client's #2's medical record illed to evidence that the I had been assessed. It on September 8, 2008, the d a quarterly review, during led that the client have a 6 months. At the time of the			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2009 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING						(X3) DATE SURVEY COMPLETED		
a Street Market	:	09G031	B. WING							R 7/2009		
СОММ	PROVIDER OR SUPPLIER UNITY MULTI SERVICE			43	EET ADDRESS, C 14 9TH STREET ASHINGTON,	r NW			03/1	772009		
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{W 322	survey, there was n received the recomi laboratory test to as Prolactin level.	o evidence the client had nended and prescribed sess and monitor the client's	{W 3:	22}								
W 331	, , , , , , , , , , , , , , , , , , , ,	vide clients with nursing	W 3	31								
NAME CC	Based on interview a failed to ensure nurs	not met as evidenced by: and record review, the facility ling services were provided in needs of two of three clients its #1 and #2)		-		÷ .						
	services failed to ens Procedures for Medi	368] The facility nursing sure that established cation Administration were ent a medication error for			e e e e e e e e e e e e e e e e e e e			*				
Ar.	2009 at approximate October 28, 2008, at administered Client #	al incidents on March 17, ly 11:30 AM, revealed that on 6:15 AM, Client #1 was 4's morning medications ad Zyprexa 10 mg) by the					٠			٠.		
	17, 2009 revealed that "Procedure for Medic provided guidelines to the staff. The review of the staff.	ation revealed the following										
ľ				. 1						1		

PRINTED: 04/07/2009 FORM APPROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	COMPLETED
			B. WING		R
ļ	<u></u>	09G031	J. 11110		03/17/2009
Į.	PROVIDER OR SUPPLIER  INITY MULTI SERVICE		s	TREET ADDRESS, CITY, STATE, ZIP COD 4314 9TH STREET NW WASHINGTON, DC 20011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
W 331	Continued From pag	je 4	W 33	The nursing staff recei	ved train
-	a. The nurse must			ing on medication error	
*.	Administer the me	dications per physician's		umentation. The primary	
	order			review the MAR on a wee	kly best
- <b>L</b> .	Prepare each clier	nt's medication and administer	•	to ensure that the nurs	ally basis
	it before preparing for	or the next client		ero following	ing starr
د.	Request assistance	e from group home staff		are following establish	ed procedu-
. ·	b. Group home staff		•	res for medication admi	mistration. 3/24/09
		a time to the room and		1 <del></del> .	· .
	remain with the clien	t until medication is			
Tel.	administered.	a dital inculcation is		· d	
			•	The Director of Nursing	
CC	The review of a the r	nedication nurse's written	2	wing the delicitud	WIII re-
راي الد	statement dated Oct	ober 28, 2008, revealed that		view the individuals me	
PRE	both Client #1 and #	4 were at the medication		cord on a quarterly bas	is. 4/24/09
	room when the medi	cation error occurred.			
	A staff summany dat	ed October 29, 2008, was			
٠.	also completed for th	e investigation of the			•
	medication error The	e staff wrote that she sent			
1	Client #4 in the direct	tion of the medication room,			
	then went to the third	floor and escorted Client #1		·	'
	to the medication roo	m. The staff noted that when	÷		
`	she arrived at the me	dication room with Client #1,			
: .	she discovered that (	Client #4 had gone back to	•		
	inetrusted and instead	of the medication room as		· · ·	
	written by the stoff ro	ther review of the statement			
	at the medication roo	vealed that she was not in or m when Client #1 received			
100 m	the medication from r	nurse. The staff noted that			
	when she arrived bac	k at the medication room			
T '   '	with Client #4, Client;	#1 was observed with an			i
17. 18.4	empty medication cup	and was drinking water.	•		
r 1900	According to 5				
	According to Procedu	re for Medication	•		
	Administration, the sta client at a time to the	aff the should bring one			'
	remain with the client	until the medication is			} · •
	administered There u	vas no evidence that the			·
J.*		ras no evidence that the			

#568 P. 007/021

		AND HUMAN SERVICES  & MEDICAID SERVICES		•	•		FORM	APPROVED 0.0938-0391
TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION NG		(X3) DATE S	URVEY
		09G031	B. Wi	NG_				R <b>7/2009</b>
	PROVIDER OR SUPPLIER  INITY MULTI SERVICE	s, inc		4:	REET ADDRESS, CITY, STATE, ZIP C 1314 9TH STREET NW WASHINGTON, DC 20011	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOL	ILD BE	(X5) COMPLETION DATE
W 331	administered it to the the next client, or recognoup home staff to medications were at the time of the surve the facility' nursing sestablished Procedu. Administration were	h client's medication and e client before preparing for quested assistance from ensure Client #1's morning dministered without error. At ey, there was no evidence that ervices ensured that the ires for Medication implemented.	W	331				
W.	2009 at approximate October 28, 2008, at administered Client (Topamax 100 mg amedication nurse. The statement documents)	al incidents on March 17, ly 11:30 AM, revealed that on 6:15 AM, Client #1 was #4's morning medications and Zyprexa 10 mg) by the ale QMRP's incident ed that the client remained the day, refusing breakfast						
	medication nurse, da aforementioned med immediately reported The medication nurse documented that she supervisor of the prin directive to hold Clier medications (includin behavior). The medic	to the nursing supervisor. e's written statement further was informed by the nursing hary care physician's at #1's prescribed morning g Fluoxetine HCL 40 mg for ation nurse's statement held Client #1's Fluoxetine						
) 	The review of the medecord (MAR) for Octo	dication administration ober 28, 2008, however						

#568 P. 008/021

PRINTED: 04/07/2009

		I AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	: 04/07/2009 I APPROVED : 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPL	URVEY
		09G031	B. Win	≀G		i i	R 7/2009
	PROVIDER OR SUPPLIER INITY MULT! SERVICE	S, INC		43	EET ADDRESS, CITY, STATE; ZIP CODE 814 9TH STREET NW (ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 331	revealed that all of medications (which mg) were initialed a the client. The revie	Client #1's morning included Fluoxetine HCL 40 s having been administered to be of the October 28, 2008	<b>W</b> 3	331			
	were circled as have the survey, there wa on Client #1's MAR morning mediation	Client #1's evening It lactulose and Rivia 25 mg), Ing been held. At the time of as no evidence documentation substantiated that her were held on October 28, with the PCP's verbal					
<b>W</b> 368	Client #2 was referred Prolactin assessment primary care physicial	ng services failed to ensure ed to the laboratory for a nt as prescribed by the an. (See W322) & ADMINISTRATION	W 3	68	Cross reference W322	·	4/24/09
	The system for drug that all drugs are ad the physician's order	administration must assure ministered in compliance with rs.					
``.	Based on interview a failed to ensure that	not met as evidenced by: and record review, the facility medication was administered of three clients in the					
	The finding includes:						Ì
	the review of an unus October 28, 2008, re error occurred at 6:1 administered Client # (Topomax 100 mg at	at approximately 11;30 AM, sual incident report dated vealed that a medication 5 AM, when Client #1 was 44's morning medications and Zyprexa 10 mg).					

#568 P. 009/021

		HAND HUMAN SERVICE				·	FORM	): 04/07/2009   APPROVED  : 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O	LIA ER:	1		TPLE CONSTRUCTION	(X3) DATE S	URVEY	
		09G031		B. WIN		NG	R 03/17/2009		
NAME OF F	PROVIDER OR SUPPLIER				STR	REET ADDRESS, CITY, STATE, ZIP COI		1772003	
СОММИ	NITY MULTI SERVICE	ES, INC			4	4314 9TH STREET NW WASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 368	Continued From pa	<del></del>		W 3	68	Cross reference W331		3/24/09	
Di CE	client's medical rec confirmed that the r There was no evide	sional and the review of ord on March 17, 2009 medication error occurre ence the facility ensured ation was administered	ed. that						
iso in									
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Health Regulation Administration

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
TATE TATE		HFD03-0052		A. BUILD B. WING			R 17/0000
	ROVIDER OR SUPPLIER		STREET ADD	PRESS, CITY	, STATE, ZIP CODE	03/1	7/2009
СОММО	NITY MULTI SERVICE	S, INC	4314 9TH WASHING				
·· (X4) ID · PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENT	rs	ŀ	{R 000}			
ST AND incell	2009. The Plan of (2008 recertification by the facility on Se focus of this revisit:	s conducted on Marc Correction for the Au survey, which was s ptember 15, 2008, w survey. The facility v and supports for six v ties.	gust 21, ubmitted as the vas				
name Cr	observations, intervi	survey were based of iews with staff and re las a review of resid ds, including the inci- n.	esidents ent and	·			
(R 125)	4701.5 BACKGROU	IND CHECK REQUI	REMENT	(R 125)			
	The criminal backgreating of the contract worker for the contract worker for the contract worker for the contract within the secheck.	he previous seven (7 thin which the prospe It worker has worked	yee or 7) years, ective		All criminal background will be obtained and pl their personnel records future, new employees wall required criminal b checks upon starting wo	aced in In the Ill obtain ackground	a 4/24/09
CATL CATL CHASE	This Statute is not n Based on interview a records, the GHMRE background checks the the employees had v seven (7) years, prio seven staff employed	and the review of per Pfailed to obtain crim for all jurisdictions in vorked or resided with r to the check for two	sonnel inal which thin the				
j.  -	The findings include:			•			
t (	On March 17, 2009, the Qualified Mental (QMRP) provided cri documentation reque subsequent review o	Retardation Professi minal background ested for review. The	onal				
BOTATORY	ion Administration  JULIU  DIRECTOR'S OR PROVIDE	RSUPPLIER REPRESENTA	ATIVE'S SIGNA	rom TURE THE	an Pieter		X DATE
ATE FORM			6899	//_	1YJ12	If continuati	on shifet 1 of 4

#568 P. 011/021

		•	A. BUILD	ING	(X3) DATE SURVEY COMPLETED R			
	HFD03-0052		B. WING		-	₹ 7/2009		
ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	<u> </u>	772009		
ITY MULTI SERVICE	S, INC	4314 9TH	TH STREET NW INGTON, DC 20011					
(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOP	JLD BE	(X5) COMPLETE DATE		
Continued From page	ge 1		{R 125}					
revealed the following	ng:							
There was no evide criminal background S7	nce of comprehension I check for direct sup	ve oport staff						
February 5, 2009 wa personnel records in	as documented for S adicated that she wa	7. Her s						
employed by the fac The review of the cri revealed that S7 res of the survey there v	ility on February 10, iminal background clided in Maryland. A vas no evidence that	2009 heck t the time t a						
comprehensive crim	inal background che	d ck for	• .					
record on March 17, no documentation was ackground check wemployment application April 3, 2008, listed elephone number who ackground check suff18/09) revealed it was ackground check revealed S1 reme of the survey, the ackground check has ackground check which has ackground check such ackground check which has ackground check such ackground check such has ackgr	2009, at 4:05 PM reas available to verify as conducted. Note ion form, signed and one former employing the review of the crimistrated post-survey as only for the District of this criminal backgraided in Maryland. Here was no evidence to been obtained for rea of prior employments.	vealed that a that a dated yer with area (dated ict of round At the that a						
	Continued From page revealed the following. There was no evide criminal background S7  A District of Columb February 5, 2009 was personnel records in employed by the fact The review of the criminal background check have background check have background check have been as the survey there was no evidenced on March 17, no documentation was background check was personnel record on March 17, no documentation was background check was personnel as the survey of the survey of the survey of the columbia. Review of the survey, the columbia. Review of the survey, the columbia of the survey of the survey. The survey of th	Continued From page 1 revealed the following:  There was no evidence of comprehensive criminal background check for direct supports of the survey there was no evidence of that she was employed by the facility on February 10, The review of the criminal background check for the survey there was no evidence that she was expended that \$7 resided in Maryland. As of the survey there was no evidence that background check had been obtained for Maryland.  There was no evidence of a timely an expense of the criminal background check had been obtained for Maryland.  There was no evidence of a timely an expense of the criminal background check for the comprehensive criminal background check in documentation was available to verify exclored on March 17, 2009, at 4.05 PM report of the criminal packground check was conducted. Note the property of the criminal packground check submitted post-survey (18/09) revealed it was only for the District of the survey, there was no evidence ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior employment ackground check had been obtained for laryland or for the area of prior	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 revealed the following:  There was no evidence of comprehensive criminal background check for direct support staff S7  A District of Columbia background check dated February 5, 2009 was documented for S7. Her personnel records indicated that she was employed by the facility on February 10, 2009. The review of the criminal background check revealed that S7 resided in Maryland. At the time of the survey there was no evidence that a background check had been obtained for Maryland.  There was no evidence of a timely and comprehensive criminal background check for direct support staff S1.  Review of direct support staff S1's personnel ecord on March 17, 2009, at 4:05 PM revealed to documentation was available to verify that a background check was conducted. Note: her employment application form, signed and dated on April 3, 2008, listed one former employer with elephone number which included a 347 area ode. Additionally, the review of the criminal ackground check submitted post-survey (dated /18/09) revealed it was only for the District of columbia. Review of this criminal background heck revealed S1 resided in Maryland. At the me of the survey, there was no evidence that a ackground check had been obtained for laryland or for the area of prior employment Area Code: 347).  This is a repeat deficiency from the August 21, 2008 Survey.)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  revealed the following:  There was no evidence of comprehensive criminal background check for direct support staff S7.  A District of Columbia background check dated February 5, 2009 was documented for S7. Her personnel records indicated that she was personnel record in Maryland. At the time of the survey there was no evidence that a packground check had been obtained for Maryland.  There was no evidence of a timely and comprehensive criminal background check for direct support staff S1's personnel ecord on March 17, 2009, at 4:05 PM revealed to documentation was available to verify that a packground check was conducted. Note: her employment application form, signed and dated an April 3, 2008, listed one former employer with elephone number which included a 347 area ode. Additionally, the review of the criminal ackground check submitted post-survey (dated /18/09) revealed it was only for the District of columbia. Review of this criminal background heck revealed S1 resided in Maryland. At the me of the survey, there was no evidence that a ackground check had been obtained for laryland or for the area of prior employment Area Code: 347).  This is a repeat deficiency from the August 21, 2008 Survey.)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  reveraled the following:  There was no evidence of comprehensive criminal background check for direct support staff S7.  A District of Columbia background check dated February 5, 2009 was documented for S7. Her personnel records indicated that she was employed by the facility on February 10, 2009. The review of the criminal background check revealed that 57 resided in Maryland. At the time of the survey there was no evidence that a background check for direct support staff S1.  Review of direct support staff S1's personnel ecord on March 17, 2009, at 4:05 PM revealed to documentation was available to verify that a background check was conducted. Note: her imployment application form, signed and dated in April 3, 2008, listed one former employer with elephone number which included a 347 area ode. Additionally, the review of the criminal background heck submitted post-survey (dated 1/18/09) revealed it was only for the District of followibia. Review of this criminal background heck revealed S1 resided in Maryland. At the me of the survey, there was no evidence that a ackground check had been obtained for laryland or for the area of prior employment Area Code: 347).  This is a repeat deficiency from the August 21, 2008 Survey.)	SUMMARY STATEMENT OF DEFICIENCIES  (RECH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSG IDENTIFYING INFORMATION)  Continued From page 1  (R 125)  There was no evidence of comprehensive criminal background check for direct support staff S7.  A District of Columbia background check dated February 5, 2009 was documented for S7. Her personnel records indicated that she was employed by the facility on February 10, 2009. The review of the criminal background check revealed that S7 resided in Maryland. At the time of the survey there was no evidence that a background check had been obtained for Maryland.  There was no evidence of a timely and comprehensive criminal background check for direct support staff S1.  Review of direct support staff S1's personnel ecord on March 17, 2009, at 4.05 PM revealed to documentation was available to verify that a background check was conducted. Note: her imployment application form, signed and dated in April 3, 2008, listed one former employer with elephone number which included a 347 area ode. Additionally, the review of the criminal ackground check submitted post-survey (dated 718/09) revealed if was only for the District of columbia. Review of this criminal background heck revealed S1 resided in Maryland. At the me of the survey, there was no evidence that a ackground check had been obtained for laryland or for the area of prior employment area Code: 347).  This is a repeat deficiency from the August 21, 2008 Survey.)		

Health I	Regulation Administr	ation		<del></del>		, OKW	APPROVEL	
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER:	(X2) MUL <sup>*</sup> A. BÜİLDI B. WING	TIPLE CONSTRUCTION NG		TED .	
NAME OF E	PROVIDER OR SUPPLIER	HFD03-0052	STREET AD	DRESS, CITY,	03/1	7/2009		
	NITY MULTI SERVICE	S, INC	4314 9TH	STREET N	W			
(X4) ID PREFIX ,,TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
{R 125}	Continued From pa	ge 2		(R 125)				
J.	GHMRP failed to er checks for all jurisdi had worked or resid	v of personnel record sure criminal backg ctions in which the e ed within the seven r two of the seven st cility.	round mployees (7) vears					
	The findings include	:						
(F)	On March 17, 2009 the Qualified Mental (QMRP) provided or documentation required subsequent review of revealed the following the control of t	Retardation Profess iminal background ested for review. The of the presented info	sional ne					
(S)	There was no evictiminal background     S7 .	dence of compreher check for direct sup	nsive oport staff				·	
ait.	A District of Columbi February 5, 2009 wa personnel records in employed by the fac The review of the cri revealed that S resid of the survey there w background check had Maryland.	is documented for Sidicated that she was dirated that she was difty on February 10, minal background ch ded in Maryland. At the des no evidence that	7. Her s 2009. neck the time					
+ (	There was no eviction	nal background che	d ck for					
(	Review of a direct su (S1) on March 17, 20 documentation was a packground check wa	09 at 4:05 PM revea	aled no					
ith Regulat	ion Administration		689					

To: 2024429430

04/14/2009 21:57

#568 P. 013/021

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER:	(X2) MULTI A. BUILDIN B. WING _	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AME OF F	ROVIDER OR SUPPLIER	HFD03-0052	STREET ACT	i	STATE, ZIP CODE	03/17/200	)9	
	NITY MULTI SERVICE	S, INC	4314 9TH	STREET NV TON, DC 2	<b>N</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COM	(X5) MPLETI (ATE	
R 125}	Continued From pa	ge 3		{R 125}				
1 	employment application form, signed and dated on April 3, 2008, listed one former employer with a telephone number in the 347 area code.  Additionally, the review of the criminal							
ę.	background checks 3/18/09) which was of Columbia. Revie check revealed S1 r	submitted post-surve revealed it was for the wof this criminal bac resided in Maryland,	he District ckground At the	-				
	evidence that a back	nowever, there was r kground check had b nd or for the area of p Code: 347).	peen					
	This is a repeat defice 2008 Survey.)	ciency from the Augu	ust 21,		,			
-				-		,		
2 -								
					•			
	ion Administration	*			•			

To: 2024429430

04/14/2009 21:57

#568 P. 014/021

	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURY COMPLETE				
		HFD03-0052		B. WING		03/17/2	onna			
NAME OF F	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY	, STATE, ZIP CODE	1 00,1772	.003			
COMMU	NITY MULTI SERVICE	S, INC		TH STREET NW NGTON, DC 20011						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE   d	(X5) COMPLETE DATE			
{I 000}	INITIAL COMMENT	S		{000 i}						
jr <sup>i</sup>	2009. The Plan of 0 2008 recertification by the facility on Se focus of this revisit s	conducted on Marc Correction for the Au survey, which was s ptember 15, 2008, w survey. The facility v and supports for six v ties.	gust 21, ubmitted as the vas							
C: ,× (-àt .₹/090}	The findings of this sobservations, intervi in the home, as well administrative recommanagement system	ews with staff and re as a review of resid- ds, including the inci-	esidents ent and							
	The interior and extermaintained in a safe	erior of each GHMRF , clean, orderly, attra	shall be	{1 090}	1. The trash can with th lid will be replaced.	i i	/13/09			
	and sanitary manner accumulations of din odors.	and be free of			2. The railings' vertica	itored				
	This Statute is not n Based on observatio March 17, 2009 surv maintain the interior orderly, and attractive	n and interview, duri ey, the GHMRP faile of the facility in a saf e manner .	ing the		weekly for disrepair.	4/	29/09			
(A)	The findings include: On March 17, 2009, lobservation of the enfollowing deficiencies	beginning at 6:05 PN vironment revealed	/I, the	-		·				
١	One of the three to was observed to have orn off, exposing jag	e approximately 2/3	k yard of the lid							
PATORY I	ion Administration DIRECTOR'S OR PROVIDE	RVSUPPLIER REPRESENTA	Prus ATIVE'S SIGN		Wheiter	4/14/0	DATE  Pheet 1 of 8			

04/14/2009 21:57

#568 P. 015/021

STATEME AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		HFD03-0052		B. WING	· ·	F	₹ <b>7/20</b> 00			
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DDRESS, CITY, STATE, ZIP CODE 03/17/2009						
COMMU	INITY MULTI SERVICE	s, inc	4314 9TH	TH STREET NW NGTON, DC 20011						
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE	s	ID	PROVIDER'S PLAN OF CORRECT	ION				
PREFIX	REGULATORY OR LE	MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL ATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D RE	(X5) COMPLETE DATE			
{l 090}	Continued From pag	ge 1		{I 090}						
Administration	2. The railing on the missing a vertical su Qualified Mental Re (QMRP) during the	upport. Interview wit tardation Profession	h the al							
<u>+</u> .	was informed that so to the vertical suppo the survey, there wa repairs had been co	ome repairs had bee orts of the stairs. At the is no evidence that the	n made			· :				
;			` <b> </b>	•						
	as a personne Each employee, pricannually thereafter, sertification that a heperformed and that it would allow him or hiduties.  This Statute is not make a performed and that it would allow him or hiduties.  This Statute is not make a performed and that it would allow him or hiduties.	or to employment and shall provide a physicalth inventory has been to perform the recent as evidenced by:  Indeed as evid	dician 's een lith status juired	{1 206}	All annual health certificates.  All annual health certificates.  Future, all employees' percords will be checked in dential Manager monthly trent health certificates.	ed in In the ersonnel by Resi-	4/24/09			
	The findings include:									
	Interview with the Qu Professional on Marc revealed that several recently hired to work	h 17, 2009, at 1:05 f direct care staff had	PM							
**	Review of the person 2009 at approximately was no health certifica	v 3:45 PM revealed t	h 17, here							
	ion Administration									
TE FORM			6899	1.	1YJ <del>1</del> 2	If continuatio	D Sheet 2 of B			

PRINTED: 04/07/2009 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBERS			A. BUILDI		(X3) DATE S COMPLI	ETED				
	HFD03-0052			B. WING		R 03/17/2009				
NAME OF F					STATE, ZIP CODE		112003			
сомми	NITY MULTI SERVICE	s, inc	4314 9TH WASHING	H STREET NW IGTON, DC 20011						
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETE DATE				
1 379	Continued From page	ge 2		1 379	In the future, the QMRP	or Resid	_			
l 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5,			1 379	ential Manager will repeallegations of abuse into the Department of He	ort all cidents				
	each GHMRP shall:	notify the Departmer	nt of		in 24hrs. Fax confirmat:	ion sheet	8			
Hea	Health, Health Facili	ties Division of any o	other		to DOH will be attached	to the				
ire M	unusual incident or cinterferes with a resi	dent 's health, welfa	are, living		Investigation Report.		4/7/09			
.	arrangement, well be	eing or in any other \	wav - [							
	places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.									
_		•				,				
.		,								
* · · · · · · · · · · · · · · · · · · ·	This Statute is not n Based on the onsite review of reports sub Health, and interview the GHMRP failed to Administration of an the six residents livin (Resident#4)	review of incident re mitted to the Depart conducted at the w notify the Health Re allegation of abuse f	ports, ment of ith staff, equiation							
T.	The finding includes:		,			ļ				
1	Review of the facility's incident reports and corresponding investigations on March 17, 2009 at approximately 1:40 PM revealed the following:						·			
	On November 17, 20 PM, the group home! notified by a day progabuse, involving Residay program. Accorday program staff alleperson was observed	s program director values and staff of an alleg dent#4 while she walling to the incident regard that a group ho	was lation of as at a eport, a me staff							
N	nterview conducted volental Retardation Properties on Administration	vith the facility's Qua rofessional (QMRP)	lified on			į	·			

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04/14/2009 21:58

#568 P.017/021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Caffi TAGE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL A. BUILD B. WING		СОМР	(X3) DATE SURVEY COMPLETED R	
708	HFD03-0052				17/2009			
COMMUNITY MULTI SERVICES INC 4314 9TH		4314 9TH	ADDRESS, CITY, STATE, ZIP CODE  TH STREET NW INGTON, DC 20011					
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE		
l·379	Continued From pa	ge 3		1379				
	incident was investing Further interview was the program directors.	1:50 PM revealed that gated by the group horith the QMRP revealed had further investigations are sures to protect the state of the stat	ome. ed that ated the					
A IC IP V	client. Through inte however, it could no allegation of abuse	erview with the QMRP of be ascertained that had been reported to th as required by stat	the the					
	had been investigate At the time of the su	review revealed the in ion by the program di irvey, however, there had been notified of the to Resident#4.	rector   was no					
1 401	3520.3 PROFESSIO PROVISIONS	ON SERVICES: GENE	ERAL	·i 401				
	and evaluation, inclu developmental level services, and service	s shall include both d iding identification of s and needs, treatment es designed to prever er loss of function by	nt nt					
i i	GHMRP failed to ens provided in accordan	net as evidenced by: and record review, the sure nursing services ace with the needs of a sample. (Residents	were two of					
1	The findings include:	·			Cross reference W331		3/24/0	
ti A n	hat established Proc Administration were in nedication error for F relow.	ng services failed to e edures for Medication mplemented to preve Resident #1 as evider	nta					

V. . . . . . ;

Health Regulation Administration

04/14/2009 21:58

#568 P. 018/021

STATEMEN AND PLAN	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		HFD03-0052		B. WING		_	R		
NAME OF P				DORESS, CITY	, STATE, ZIP CODE		/17/2009		
A	NITY MULTI SERVIC	ES, INC	4314 9TH	I STREET N GTON, DC	lw .		**		
7. (X4) ID PREFIX TAG	TIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
1 401	Continued From pa	ige 4		I 401					
	2009 at approxima on October 28, 200 was administered F	ual incidents on Marc tely 11:30 AM, reveal 18, at 6:15 AM, Resid Resident #4's moming max 100 mg and Zyp tion nurse.	ed that ent #1						
, CO:	17, 2009 revealed in Procedure for Med provided guidelines the staff, he review	Director of Nursing on hat the agency had a lication Administration to the medication nu of the "Procedure for tration revealed the foccur:	written " which rse and						
	ordered Prepare each resi administer it before resident	dedications per physicition and preparing for the nextee from group home s	di t						
i	b. Group home staff Bring one resident remain with the resided administered.	must at a time to the room dent until medication	and is						
CO. Co.	completed for the in- error. The staff wrote he direction of the n he third floor and es nedication room. Th	ted October 29, 2008 vestigation of the mede that she sent Resided that she sent Resided that who staff noted that whation room with Resident #1	dication ent #4 in went to the en she						
to a	the discovered that to her bedroom, inst is instructed earlier. tatement written by	Resident #4 had gone ead of the medication Further review of the the staff revealed that	e back room	·					
ealth Regulation	on Administration		<del> [,</del>						

#568 P. 019/021

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM  HFD03-0652			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED R 03/17/2009		
AME OF F				DRESS, CITY	, STATE, ZIP CODE	03/1	712009
COMMU	NITY MULTI SERVICE	ES, INC	4314 9TH	STREET N	1W		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
1401	Continued From page 5 was not in or at the medication room when Resident #1 received the medication from nurse. The staff noted that when she arrived back at the medication room with Resident #4, Resident #1 was observed with an empty medication cup and was drinking water.  According to Procedure for Medication Administration, the staff the should bring one resident at a time to the medication room and remain with the resident until the medication is administered. There was no evidence that the nurse prepared each resident's medication and administered it before preparing for the next resident or requested assistance from group			1401	The medication nurse additional training o of Medication Adminis	n Procedur	s 3/24/09
	medications were as the time of the surve the GHMRP' nursing established Procedu Administration were 2. The GHMRP's nu	e Resident #1's morr dministered without e ey, there was no evid g services ensured the ures for Medication implemented. rsing services failed #1's medication error	error. At lence that nat the				
	accurately documen The review of unusu 2009 at approximate on October 28, 2008 was administered Re medications (Topam mg) by the medication	ted:  al incidents on Marcely 11:30 AM, revealed, at 6:15 AM, Resident #4's morning ax 100 mg and Zypron nurse. The QMRF ocumented that the reproughout the day, re	h 17, ed that ent #1 exa 10 o's resident				
1	nedication nurse, da aforementioned med	ten statement by the ted October 28, 200 ication error was I to the nursing supe	8, the				

04/14/2009 21:58

#568 P. 020/021

STATEMEI AND PLAN	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BŲILDI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WANG			(X3) DATE SURVEY COMPLETED R	
	HFD03-0052			B. WING			03/17/2009		
COMMUNITY WHI TI SEDVICES INC. 4314 9TH			DDRESS, CITY, STATE, ZIP CODE  H STREET NW IGTON, DC 20011						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOLE TAG CROSS-REFERENCED TO THE APPRI DEFICIENCY)			JLD BE	(X5) COMPLETE DATE	
j l 401	Continued From pa	ge 6	,	1401		-			
o e	The medication num documented that sh nursing supervisor of directive to hold Res	se's written statement was informed by the primary care posident #1's prescribe s (including Fluoxetic). The medication nurted that she held Re	ne hysician's d ne HCL rse's			•			
	The review of the marecord (MAR) for Occrevealed that all of Formedications (which img) were initialed as the resident. The remarked that Formedications (except were circled as having the survey, there was on Resident #1's MA morning mediation was 2008, in accordance directive.	edication administration administration 28, 2008, how Resident #1's morninincluded Fluoxetine Is having been adminiview of the October Resident #1's evening lactulose and Riviang been held. At the sino evidence docurur substantiated that were held on Octobe	ever g HCL 40 istered to 28, 2008 g 25 mg), time of nentation t her r 28.						
¥	3. The GHMRP faile laboratory assessme one of three resident #2)	ents were obtained tip	melv for				·		
	On March 17, 2009, a review of Resident #2 revealed a Novembe Prolactin Level". Fun a December 29, 2008 stated "Prolactin Leve	2's physician's orden r 26, 2008 order to " ther record review re B physician's order w	s (POs) Monitor evealed		Cross reference W322			4/24/09	
	Interview with the Que Professional (QMRP) PM revealed there we for Resident #2. Furt	on March 17, 2009 ere no Prolactin leve	at 2:35						

To: 2024429430

04/14/2009 21:58

#568 P. 021/021

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  WEDO: 0062			(X2) MULT A. BUILDIN B. WING	TIPLE CONSTRUCTION  NG	COMPL	(X3) DATE SURVEY COMPLETED R	
111115		HFD03-0052					7/2009
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
	NITY MULTI SERVICE		WASHING	STREET NOT 2			٠
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
1 401	Continued From page	ge 7	-	1401 :			
entering and the second se	Director of Nursing Prolactin level had t	ould follow-up with to determine if Resid been assessed as pr	lent #2's escribed.				
He. STATE CAPT TA	record on March 17	ctin level had been a nat on September 8, ed a quarterly review	ence that ssessed. 2008, the			: 	
N.	"Prolactin level ever the survey, there wa had received the rec laboratory test to as- resident's Prolactin I	y 6 months. At the ti as no evidence the re commended and pre- sess and monitor the	me of esident scribed				
			· .	-		-	•
He	3						
STATE			_				,
			İ		·		
:1							
				·			
						·	
	· 		·		• .		
alth Regulat ATE FORM	ion Administration		689	• I1	YJ12	If continuati	on sheet 8 of 8